TEMPLATE OF KEY ELEMENTS WHICH MUST BE CONSIDERED WHEN DEVELOPING A COMPREHENSIVE, EFFECTIVELY WORKING STATE PLAN FOR MOVING PEOPLE OUT OF INSTITUTIONS AND INTO APPROPRIATE COMMUNITY SETTINGS

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Introduction

In *Olmstead v. L.C. and E.W.*, 119 S.Ct. 2176 (1999) the Supreme Court stated loud and clear that the denial of community placements to individuals with disabilities is precisely the kind of segregation that Congress sought to eliminate in passing the Americans with Disabilities Act (ADA). The Supreme Court correctly noted that unnecessary segregation and institutionalization constitute discrimination and violate the ADA's "integration mandate" unless certain defenses are established. The decision presents new opportunities for advocating for community-based services and supports for people with disabilities.

The decision says a state may have a defense to lawsuits challenging the state's failure to serve individuals in the most integrated setting appropriate if it has a "comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings."

The Court did not define a "comprehensive" plan. It seems appropriate that a "comprehensive" plan is one that addresses the placement needs of all individuals who are unnecessarily institutionalized or at risk of institutionalization. A state may have different plans to address different populations, as long as the needs of all individuals unnecessarily institutionalized are addressed. Neither does the Court define "effective." It seems logical however that an "effective" plan must have certain important elements.

This template is designed as a tool to help advocates participating in the development of state plans to ensure that they consider certain important elements that any state plan should have. The template is intended as a baseline and not as a model plan. Advocates should add to this list as necessary taking into account the circumstances of your state. It is important to understand that any plan that is developed will need to be modified as circumstances change. The state plan should be considered to be a working document that should be reviewed at regular intervals (at least annually). The steering committee that develops the plan (including key stakeholders) should also be the group that continues to review the plan. Forums or other methods of soliciting the opinions of consumers, family members, providers, etc., should be held regularly to ensure broader stakeholder input.

The guiding principle reflected in this template is that the state must develop and enhance community programs and services so that each individual resident can move to the most

integrated setting appropriate to meet his or her needs. The community program and service shall promote choice, independence and dignity.

Element One: PARTICIPATION OF KEY STAKEHOLDERS IN THE DEVELOPMENT OF THE PLAN

Stakeholders should include representatives of those who receive, provide, administer, and monitor disability services. Advocates need to press state or local government officials to include all of these groups in the process of developing the state plan. Inclusion means more than just inviting a representative to participate, it also means ensuring that accommodations are offered that will allow full and meaningful participation for each stakeholder representative. For example, assistance might be provided with regard to reading and understanding materials, holding meetings in accessible locations, transportation to and from meetings, provision of childcare or respite services etc.

Key stakeholders may include, but are not limited to representatives from:

- consumer self advocacy groups, for example, The Arc, independent living programs, associations for the mentally ill, mental health consumer groups or for individuals with psychiatric disabilities, groups for those with sensory impairments, physical disabilities and AIDs,
- area agencies on aging and other senior citizen groups,
- veterans organizations,
- hospice programs,
    - the state legislature,
- state agencies, for example, Department of Mental Retardation or Developmental Disabilities, Department of Medicaid, Medicare, and Social Security, Department of Special Education , Department of Transportation, Department of Housing
- protection and advocacy agencies
- developmental disabilities councils
- community mental health centers,
- providers of home based care, and respite care,
- vendors of assistive technology,
- nursing homes,
- residential treatment facilities
- state and community hospitals,
- the medical community, nurses, social workers and case managers.
- housing providers; advocacy groups

Element Two: NEEDS ASSESSMENT PROCESS

Often states do not take the time to figure out the type and quantity of services and supports that need to be developed in the community to support persons with disabilities, nor is there a clear process for determining who needs services (e.g. the waiting list is often not well defined). This often results in a lack of community capacity which then

gets used as an excuse for not providing community supports. Also assessments must not be shaped from a consideration of the current availability or existence of a needed service or support.

This step in the planning process should be done on an ongoing basis, but should not delay the process of moving people for whom adequate supports can be readily identified. For other people, there will need to be more planning. For example, serving people with complex medical needs in rural areas will require some creative thinking. A needs assessment would help to identify these needs and allow for adequate planning.

Individual assessment should include:

- identification of who should conduct the assessments, what qualifications must they have, do you want a team, if you have a team of assessors, who must be included on that team, and what qualifications must they have
- reasonably paced schedule for assessing all currently institutionalized persons
- schedule for accessing all people in the community who may be at risk of unnecessary institutionalization
- schedule for accessing, on an ongoing basis, new persons who develop disabilities and need community supports
- assessments should be conducted by qualified professionals who specifically consider such factors as the array of services an individual needs, the types of services that could be provided in the community, and any reasonable accommodations that might be required to enable the individual to benefit from particular services
- part of the assessment should include at least one face-to-face consultation with person who is being assessed for appropriateness for community placement. At the least this consultation should identify what the specific interests, goals, likes and dislikes and support needs of the individual which may factor into whether community placement is the most appropriate setting for the individual. This face-to-face consultation should be conducted using the individual with the disability's preferred method of communication
- the individual being assessed for community placement must be given the opportunity to visit and temporarily test out a choice of community services options prior to being asked to chose where one wants to live.
- a written individual support plan that is reviewed and revised upon the request of the individual or guardian, and at least yearly.
- transition services to assist the individual to make a smooth change to the community.

Element Three: DEVELOPMENT OF NEW COMMUNITY SERVICES AND SUPPORT INFRASTRUCTURE

A comprehensive plan should identify new and expanded community services and supports that will be made available in the community to respond to the increased demand for these services that will result from unnecessarily institutionalized persons